

Title: Autism Program Restraint and Seclusion Policy

Purpose:

Participants served shall have the right to be free from the unreasonable, unsafe, or unwarranted use of restraint or seclusion for the purposes of discipline, punishment or staff/provider convenience. Service providers are expected to use positive behavioral support methods. If restraint or seclusion is used as safety intervention, it should be the method of last resort. Restraint and seclusion are not treatment interventions. It is inappropriate to use these methods instead of providing adequate levels of staff. If such methods are used for the purpose of behavior intervention, all such methods must follow the prescribed process. If the participant is known to have any medical condition such that restraint or seclusion may endanger his/her health and safety, this process is prohibited.

Definitions\*:

1. Restraint – any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the participant's body.
2. Personal Restraint – means the application of physical force without the use of any device, for the purposes of restraining the free movement of a participant's body.
3. Drug used as Restraint – Any drug that:
  - (1) Is administered to manage an participant's behavior in a way that reduces the safety risk to the individual or others;
  - (2) Has the temporary effect of restricting the participant's freedom of movement; and
  - (3) Is not a standard treatment for the participant's medical or psychiatric condition.
4. Mechanical Restraint – Any device attached or adjacent to an participant's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.
5. Seclusion – means involuntary confinement of a participant alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.
6. Time out – means the restriction of a participant for a period of time to a designated area from which the participant is not physically prevented from leaving for the purpose of providing the participant an opportunity to regain self-control.

\*Definitions are excerpted from The Centers for Medicaid and Medicare Services Home and Community-Based Services Waiver Application Glossary of Terms and Abbreviations.

For this policy, 'physical restraint' is equivalent to 'personal restraint' and 'chemical restraint' is equivalent to 'drug used as restraint'.

Procedure:

1. The use of restraint or seclusion is prohibited except:
  - 1.1 For an emergency;
  - 1.2 For the safety of the participant and/or others around him/her (imminent risk of harm)

Imminent Risk of Harm – means an immediate and impending threat of causing substantial physical injury to self or others.

2. If by recorded history or recent event(s), it is determined that a participant is likely to have recurring behavioral episodes that puts the participant or others around him/her at risk of harm, then the participant's support team shall conduct the following:

2.1 Functional Assessment of the behavior which includes clear data-based demonstration of other less restrictive behavior intervention strategies that have been implemented and proven ineffective.(Resources: KCART, KIPBS);

2.2 Risk Assessment

3. If the decision is made to use restraint or seclusion, it must be defined in the IBP (Individualized Behavior Plan) and include the items below:

3.1 The topography;

3.2 The function of the behavior;

3.3 Where the seclusion can occur or specifically how the restraint may occur;

3.4 The maximum length of any period of restraint and/or seclusion;

3.5 The maximum number of times during a single day restraint and/or seclusion may be used;

3.6 As applicable, other conditions defined by the support team;

3.7 Provider shall facilitate efforts to define alternative methods of behavior management to keep the situation from escalating to emergency status following any such episode (e.g. change environment, reduce exposure, redirect, change instruction, provide visual supports);

3.8 Specific data to be collected for each instance of restraint and/or seclusion (e.g. frequency of behavior, additional conditions of behavior, steps/responses to behavior, procedural safeguards utilized), shall include number of times the restraint and/or seclusion occurred within a fixed period of time;

3.9 Frequency and criteria for notification to the Autism Specialist and the guardian;

- 3.10 Date of review shall be within 30 calendar days of implementation of the IBP to determine the effectiveness of and necessary adjustments to the restraint and/or seclusion plan by the participant's designated team members to include parent/legal guardian and Autism Specialist. A team meeting may be convened at any time to review and possibly make changes in the use of intervention. Any plan developed by the team shall be signed by the participant's parent/legal guardian to document his/her approval. No plan shall be implemented with the participant's parent/legal guardian's consent.
- 3.11 Following initial review, on-going review of restraint and seclusion will be part of the IBP review every 6 months or more often as deemed necessary by the designated team members.
4. When restraint or seclusion is used, according to plan or emergency and as soon as possible after, the immediate staff and, if available, witnessing staff will document the use of the restraint and/or seclusion, as follows.
  - 4.1 Description of the antecedents (e.g. environmental conditions, activity, who was working with the participant, other individuals in the area) immediately preceding the use;
  - 4.2 The specific behavior being addressed (e.g. number of occurrences, duration, description based on operational definition);
  - 4.3 The alternative strategies used to de-escalate the situation prior to use (e.g. sensory stimulation, choices, redirect to preferred activity);
  - 4.4 How the restraint and/or seclusion ended, including physical, medical and behavioral status of the participant (e.g. injuries, medical care provided, 10 seconds of calm and discontinuation of restraint and/or seclusion);
  - 4.5 What happened after implementation of the restraint and/or seclusion (e.g. participant demonstrated behavior again, participant left the room);
  - 4.6 From on-set of behavior to discontinuation of the restraint and/or seclusion, staff reflect on and document the Individualized Behavior Plan strategies they would implement again or they would use differently;
  - 4.7 Notify Autism Specialist, as identified in the Individualized Behavior Plan;
  - 4.8 Notify parent/legal guardian, as identified in the Individualized Behavior Plan.

Critical Incident Reporting and documentation of needs to be addressed

Number/percent of restraints/seclusion, of unexpected deaths, of unauthorized use of restrictive intervention that were appropriately reported. Where is this reported? KDADS & MCO needs to be included in the process? Reporting of this would go to the participant's care coordinator at the MCO and to KDADS – we also need to know how often this is reported. A typical event is different from Critical Events

5. During the period of restraint and/or seclusion designated personnel must have the ability to see and hear the individual at all times.

6. No more than one individual at a time may be placed within one seclusion space.
7. Designated Seclusion Rooms must provide room for the participant to lie down, stand and move. Any area utilized for seclusion must meet the following specifications:
  - 7.1 At least 36 square feet;
  - 7.2 Equipped with heating, cooling, ventilation and lighting comparable to remainder of building;
  - 7.3 Free of objects that pose a danger;
  - 7.4 Equipped with a door that locks only if the lock automatically disengages when a person on the exterior of the door moves away.
8. Personal and/or Mechanical restraint should be appropriate to the severity of the child's behavior, size and physical strength/capabilities of the participant and the least restrictive strategy possible to reduce the likelihood of harm.
9. Personnel implementing restraint and/or seclusion must be properly trained and knowledgeable of the following:
  - 9.1 Methods of safely escorting the participant ;
  - 9.2 Methods for implementing the restraint and/or seclusion;
  - 9.3 Supervision of the participant while in restraint and/or seclusion;
  - 9.4 Understanding of rules governing seclusion and restraint practices;
  - 9.5 Training is conducted within specific timelines of a nationally recognized, best practice training curriculum specific to restraint and should include, at a minimum:
    - 9.5.1 Proper use of positive behavior supports, techniques and strategies designed to minimize and prevent the need for use of restraint;
    - 9.5.2 Safe administration of restraint;
    - 9.5.3 Physical safety during emergencies;
    - 9.5.4 Identification of the effects of restraint on the participant restrained, physical signs of distress and need for medical attention;
    - 9.5.5 Simulated experience of administering and receiving restraint.
  - 9.5.5 Proof of appropriate training should be documented in providers file.

NOTE: Restraint plan shall not be required for medication prescribed by a health care professional for the purpose of providing comfort in preparation for a specific medical procedure. However, consent for the medication must be obtained if administered by the provider.

At no time shall aversive behavioral interventions such as application of noxious, painful, intrusive stimuli or

activities intended to induce pain such as electric skin shock, ice applications, hitting, slapping, pinching, kicking, hurling, strangling, shoving, deep muscle squeezes or other similar stimuli; any form of noxious, painful or intrusive spray, inhalant or tastes; withholding sleep, shelter, bedding, bathroom facilities or clothing; contingent food programs that include withholding meals or limiting essential nutrition or hydration or intentionally altering staple food or drink in order to make it distasteful; movement limitation used as a deterrent such as helmets, immobilized wheelchairs, removal from wheelchair. The term aversive does not include such interventions as voice control, limited to loud, firm commands; time-limited ignoring of a specific behavior; token fines as part of a formal token economy system; brief physical prompts to interrupt or prevent a specific behavior; interventions medically necessary for the treatment or protection of the individual; or other similar interventions.